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Surgical morbidity and mortality meetings

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Summary

Morbidity and mortality meetings aim to improve the standards of surgical care, and are now required in all hospitals responsible for training junior surgical staff. If they are to receive support and achieve their aim, they must be carefully planned and well organised. This paper outlines considerations in setting up morbidity meetings and in making them a success.

Introduction

Morbidity and mortality (M & M) meetings are by no means a new concept, but discussion about them has intensified recently, and this accompanies a general move towards improved audit and quality control in surgical practice. The Confidential Enquiry into Perioperative Deaths *(1)* has focused attention on the importance of identifying deficiencies in our standards of care; while increasing litigation with expensive settlements provides an added stimulus to avoiding problems caused by poor management or negligence. As a practical step, the Royal College of Surgeons of England has demanded that each hospital should now hold regular M & M meetings in order to receive recognition for the training of junior surgical staff *(2)*.

Many hospitals already hold communal M & M meetings and a wide range of different formats exists. In other hospitals which do not have communal meetings, individual firms often hold regular sessions of their own, but these have been criticised as 'incestuous' because they exclude useful comments which might be made at a more general assembly. They do, however, allow a very detailed review, and can provide the data for a communal meeting.

There remain surgeons, practising self-critically and well, who have never been involved in regular M & M meetings and who see little to be gained from them. Even in hospitals which have communal meetings there are often one or two surgeons who do not attend. If M & M meetings are to be worthwhile, beneficial, and well supported they must be carefully planned and well run.

This article sets out some of the considerations in planning communal M & M meetings. These are based on my own observations of meetings in different hospitals, and on my experience in starting communal meetings in a district general hospital. References are also made to the views expressed at the Symposium on Quality Control and Audit at the Royal College of Surgeons of England (RCS) in December 1987. The participants at this symposium included surgeons from hospitals throughout the country, who used individual computer terminals to register their responses to questions about their practices and views on surgical audit and in particular M & M meetings.

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The schedule for M & M meetings

HOW OFTEN SHOULD MEETINGS BE HELD?

Once a week is convenient if space can be found in the weekly timetables of all concerned. However, in the busy hospital, finding a time when all members of the surgical teams can congregate may be extremely difficult. Of those at the RCS symposium who held regular meetings only 19% did so weekly, while 53% met every 2–4 weeks. Most hospitals have an hour of the week already set aside for a surgical meeting, devoted to case presentations, lectures, and the like, and adding an M & M meeting to this may make the proceedings unacceptably long. Alternating between a presentation of some kind one week and an M & M meeting the next is one solution. Another problem with meetings once a week for the smaller hospital is that insufficient problems may have occurred to fuel an adequate length of discussion, and frequent meagre meetings can lead to disenchantment.

Different solutions may be appropriate for different hospitals. In general the pattern of work in teaching hospitals allows time for more frequent meetings, and weekly meetings are more common in teaching hospitals than in district general hospitals. The most important principle is that these meetings should be regular, and if they can be held weekly in larger hospitals this is probably ideal. Where this is not possible, a system of regular weekly audit meetings for individual firms, with fortnightly communal M & M meetings based on data from these, provides an excellent alternative.

WHAT TIME OF DAY SHOULD MEETINGS BE HELD?

Morbidity and mortality meetings should form part of the routine commitment of a surgical department, and

55% of those at the RCS symposium thought that they should be a contractual requirement for all surgeons. Ideally, therefore, they should be held within contracted sessional time (9 am–5 pm), and even among those who felt that they should remain voluntary 85% shared this view. Nevertheless, current patterns of work seldom allow this, and 70% of meetings are at present held outside the hours of 9 am–5 pm.

Many hospitals are faced with a choice between out-of-hours meetings, considerable inconvenience in a busy working week, or a longer-term strategy aimed at setting aside sessions during the day for this kind of activity to take place. The latter should be the eventual goal and will not only require surgeons to make changes in their working weeks, but will also demand the full co-operation of employing authorities in facilitating these changes. As new consultants are appointed these matters should be carefully considered in constructing time-tables, rather than simply perpetuating existing weekly programmes with inadequate provision for communal academic and M & M meetings.

There is a good case for holding meetings at a mealtime—either breakfast or lunch—with provision of food. This encourages both attendance and contentment, particularly on the part of many juniors.

HOW LONG SHOULD MEETINGS LAST?

If meetings are held every week or fortnight, then an hour should be ample, and 80% of those attending the RCS symposium had meetings lasting an hour or less. I limit our meetings strictly to 45 min.

Participants—medical and non-medical

WHICH SURGICAL DISCIPLINES SHOULD ATTEND?

The current thrust at establishing M & M meetings is aimed primarily at general surgery, although they are equally appropriate and desirable for other disciplines. The majority of those attending the RCS symposium had only general surgeons at their meetings, although some involved other surgical specialties, and a few had meetings involving all disciplines. However, detailed discussion of general surgical problems can be tedious for other specialists, whose relatively low incidence of complications and deaths may make them infrequent contributors. It seems best for each branch of surgery to have its own meeting, although in Exeter we welcome other surgical specialists whenever they wish to attend.

Surgical deaths are often intimately related to anaesthetic management, and 85% at the RCS symposium felt that anaesthetists should be encouraged to attend these meetings. It is probably best to invite anaesthetists when cases of specific interest to them will be discussed.

SHOULD NON-MEDICAL STAFF ATTEND?

At the RCS symposium 28% of participants had meetings which were regularly attended by nurses, and 52% felt that senior members of the nursing staff ought to attend. Fewer subscribed to the view that all available nurses should come to M & M meetings.

The question of hospital managers attending meetings was also raised at the RCS symposium. Half of the participants thought that it was acceptable for managers to attend by invitation, while the remainder were equally divided between those who thought that they should attend as a right, and those who felt that they should have no access. By attending M & M meetings managers could gain valuable insight into clinical problems and into the deep concern of surgeons with morbidity. However, there might be occasions when the presence of a non-clinical member of staff would hamper free expression of views. Occasional invitation of hospital managers to meetings should certainly be considered.

The question of allowing other members of staff to be present at surgical M & M meetings must be a matter for local discussion and preferences.

CHAIRMANSHIP OF MEETINGS

Lively debate is often attributable to a good chairman, and M & M meetings benefit from this kind of leadership. A chairman can select cases, guide discussion, invite comments from appropriate individuals, involve and encourage reticent junior staff in debate, and perhaps form a bastion against undue acrimony or unfair criticism.

Over half of those at the RCS symposium had their meetings chaired by different surgical consultants in rotation, and I strongly support this practice, which provides informed and equitable debate. Nevertheless, some hospitals regularly have the senior surgeon (10%) or a junior (18%) in the chair.

Another option is to involve other specialists, such as pathologists, physicians, or anaesthetists as chairmen. This may have the advantages of providing an outside point of view and of creating an atmosphere of impartiality on the part of the chairman, but the limited surgical knowledge of other specialists is a disadvantage.

Collection and presentation of data

HOW SHOULD DATA BE COLLECTED?

Complications which resolve are easily forgotten, and those who audit their results know how even the death of patients can quickly pass into the recesses of the surgical memory. Unless these events are recorded at the time some will inevitably be omitted, and inadvertent omission is only a short step from excluding inconvenient or embarrassing problems.

A morbidity book on each ward is a good option, with one member of the team having responsibility for its upkeep.

However often communal M & M meetings are held, each firm's own record should be reviewed weekly, both for discussion and to ensure that no omissions have occurred. Frequent review is also important when data is being fed into a computer.

WHAT DATA SHOULD BE PRESENTED?

If M & M meetings are to achieve their aim of improving surgical management *all* problems should be presented for potential discussion. Meetings at which one or two preselected cases are presented by each firm conceal many aspects of morbidity which could usefully be discussed. Relatively minor complications may sometimes provide more instructive discussion for surgical trainees than prolonged consideration of a highly complicated case. In addition, a complete list of complications allows recognition of a high incidence of particular problems, such as infections of one kind or another, which may be relevant to the practice of the hospital as a whole.

HOW SHOULD DATA BE PRESENTED AND BY WHOM?

A full list of all morbidity and mortality for the period under review should be available for all to see. This can conveniently be done either by displaying each firm's M & M summary on an overhead projector, or by supplying photocopied lists to all those who attend.

When a question is raised about any case the best explanation comes from the clinician most closely involved with that part of the patient's management. For questions relating to a surgical procedure this will be the operating surgeon, while for matters relating to ward management some other member of the surgical team may be better placed to describe events and justify decisions. Formal presentation of cases by one member of the team is a less satisfactory approach. In addition, not selecting cases for presentation before the meeting makes those involved in the treatment of any patients with complications give thought to their management in the knowledge that they may be asked to justify their actions. This helps to cultivate a self-critical approach.

Confidentiality and medicolegal implications

At the RCS symposium over 60% participants expressed some concern about confidentiality and legal liability at M & M meetings, although less than 20% were very worried about this.

It may be best for the identity of patients listed on M & M summaries to be withheld, and the Medical Defence Union supports this view. Although there is no specific contraindication to identifying patients, the members of other surgical teams attending the meeting are not directly involved in the patient's care, and there is no special need for them to know each patient's name. It is probably sufficient to present the patient's initials, age and sex.

The relationship between M & M meetings and full surgical audit

Setting up M & M meetings is relatively straightforward compared with the more complex business of instituting a full, computerised surgical audit. Unfortunately, the distinction between these two exercises can become blurred in discussions about quality control in surgery. Morbidity and mortality meetings can be started without the need for complicated data collection, special training of personnel, computers, and the like, which are involved in setting up a full-scale surgical audit. In addition, presenting a full audit of patients passing through all the surgical wards at each communal meeting may be excessive, although it provides instructive insight into the working practices of other firms.

Whether or not a communal database has been set up, each individual surgeon or firm in a hospital should keep their own audit, which should be reviewed frequently and regularly, and the morbidity data gleaned from this can then be considered at the communal M & M meeting.

The eventual aim of all surgical departments ought to be a full computerised audit of their practices. Morbidity and mortality data can readily be harvested from such a system, but this is only one of the advantages of computerising surgical records.

Conclusion

Few would disagree with the basic philosophy behind communal M & M meetings. However, there is a risk that some surgeons will view the exercise with suspicion as an opportunity for others to expose their deficiencies and to score points. The format and leadership of these meetings must be carefully developed with a view to avoiding this danger, while encouraging the essential elements of openness, honesty, and thoughtful criticism. Morbidity meetings should aim to deter, rather than simply expose, inappropriate surgical management. The combination of spontaneous discussion and well-informed comment which good M & M meetings should provide can make them welcome and popular sessions, while ensuring their success in improving the standards of surgical care.

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References

1 Buck N, Devlin HB, Lunn JN. The Report of a Confidential Enquiry into Perioperative Deaths. London: Nuffield Provincial Hospitals Trust and King's Fund Publishing Office, 1987.

2 Application form for hospitals seeking recognition for surgical training. Royal College of Surgeons of England, 1987.

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